# Minnesota Dental Therapist Licensure Application Checklist

**You must submit the following documents at the time of application for licensure. Use this checklist to ensure that you have included the required documents. Applications with documents missing or not acceptable will be mailed back to you.**

☐ Completed Application Form *(All 4 pages complete)*

☐ Certificate of program completion *(Original, NO copies)*

☐ Clinical Exam *(Original or notarized copy)*

☐ Minnesota Jurisprudence Exam *(Original or notarized copy)*

*Information on the Jurisprudence Exam may be found at*
http://mn.gov/boards/dentistry/licensure/jurisprudence.jsp

☐ CPR Card *(Copy, ONLY American Heart Association or American Red Cross healthcare provider courses are acceptable)*

☐ Check or money order payable to the Minnesota Board of Dentistry for the amount listed on Page 1 of the application.

**The following items must be included if they apply to you:**

☐ Affidavit of Licensure *(Original document, required only if you are or have been licensed as a dentist, dental therapist, dental hygienist, or registered/licensed dental assistant in another state, Canadian Province, or country)*

☐ Collaborative Management Agreement *(If applicable. This document is required prior to practicing dental therapy)*

☐ Response to disclosure questions *(Required only if you answer Yes to any of questions 15-19)*

**If you intend to provide Nitrous Oxide, you must submit the Nitrous Oxide application form.**

The Nitrous Oxide Application form can be found at:
http://mn.gov/boards/assets/Nitrous%20Appl.%20Revised%2010-2015_tcm21-76069.pdf

Lic # _____

Issued _____

App # _____

**MINNESOTA BOARD OF DENTISTRY**
2829 University Avenue SE, Suite 450
Minneapolis, Minnesota 55414
(612) 617-2250 (888) 240-4762
MN Relay Operator for Hearing and Speech Impaired
(800) 627-3529

# APPLICATION FOR LICENSURE BY EXAMINATION TO PRACTICE AS A DENTAL THERAPIST

## NON REFUNDABLE FEE DUE - $254.75

(Application Fee $100.00; Background Check Fee $34.75; Initial Fee $120.00)

**Instructions.** Each item on this application must be answered fully, truthfully, and accurately by the applicant. Fraud or deception in securing a license is a gross misdemeanor and cause for revocation or suspension of a license. If space for any answer is insufficient, the answer may be completed on another piece of paper. Please specify the number of the item, sign it, and attach it to the rest of the application. BE SURE ALL FOUR PAGES OF THIS APPLICATION AND ITS ATTACHMENTS ARE COMPLETED.

**Minnesota Government Data Practice Act Notice.** This notice is given pursuant to Minnesota Statutes §13.04, subdivision 2, and §13.41, subdivision 2. In order to be licensed, you must submit all the information requested in this application. The Board will use the information to determine if you meet statutory and rule requirements for licensure. Accordingly, OMISSIONS OR INACCURACIES ARE GROUNDS FOR DENYING YOUR APPLICATION. All data, except your name and address, submitted by you or on your behalf are considered private until you are licensed, at which point the data become public. "Private" is defined by law as information which is accessible only to: you; the staff and members of the Board; the Board's legal counsel; any person to whom the Board must refer the application or parts thereof for verification purposes or for otherwise determining your qualifications; and to persons you designate. In addition, if the matter of your license becomes contested and thereby results either in a contested case hearing or litigation, the data submitted by you or on your behalf may also become accessible to the Minnesota Office of Administrative Hearings, appropriate courts, and those associated with such proceedings, and thereby become public data.

**Americans With Disabilities Act.** It is the policy of the Minnesota Board of Dentistry to comply with the Americans With Disabilities Act (ADA). The ADA provides, in part, that qualified individuals with disabilities shall not be excluded from participating in or be denied the benefits of any program, service or activity offered by the Minnesota Board of Dentistry. If you require additional information about the Minnesota Board of Dentistry's ADA policy please contact the Minnesota Board of Dentistry's designated ADA coordinator.

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*****PLEASE TYPE OR PRINT IN INK*****

## BACKGROUND

| | | | |
|---|---|---|---|
| 1. | Name (last, first, middle) | | Today's Date |
| 2a. | Mailing Address (street) | City, State, Zip | |
| 2b. | Primary Practice Address (street) (required if employed) | City, State, Zip | |
| 3. | Telephone (include area code)<br>( ) | Email Address (mandatory) | |
| 4. | Sex<br>❑ Male ❑ Female | Birthdate | Social Security No.<br>_____--_____--_____ |
| 5. | Other name(s) by which you are or have been known and reasons for change | | |

## DENTAL THERAPY EDUCATION

| | | |
|---|---|---|
| 6. | Dental Therapy Program | |
| 7. | Location | Date of Graduation (month, day, year) |
| 8. | Certificate (attach an original certificate of program completion): | |

## EXAMINATIONS

| Month | Day | Year |
|---|---|---|
| | | |
| | | |

9. CLINICAL EXAMINATION FOR LICENSURE - Date Completed
   Attach a notarized copy of passing one of the following:
   - **CRDTS- DT within 5 years prior to application ……..**

10. MINNESOTA JURISPRUDENCE EXAMINATION - Date Completed
    **Attach an original or notarized copy of proof of passing the exam. The Jurisprudence examination must be passed within 5 years prior to application.....**

11. List other national, regional, state, or Canadian Province licensure examinations (give names and dates of each examination and indicate any failures.)

## PROFESSIONAL BACKGROUND

12. List each state, Canadian Province and country where you are or have been licensed to practice dentistry, dental therapy, dental hygiene, and/or dental assisting:

_____

13.

**AFFIDAVIT OF LICENSURE**

This Affidavit of Licensure, copy thereof, or official letter that includes this information must be completed by the licensing authority of each state, province and country listed in item 14**. <u>The original document</u>**, containing an official signature and seal, must be submitted.

I, _____ Secretary/Chair of the _____

_____ hereby certify that _____

was granted license number _____ to practice as a _____ in the state/province of _____
(profession)
on the _____ day of _____, _____, and that this license is: ❑ active ❑ terminated _____.
(month) (year) (date)
I further certify that disciplinary action: ❑ has been taken against said licensee* ❑ has not been taken against said licensee; **<u>AND</u>**

❑ is pending* ❑ is not pending ❑ that pending disciplinary action cannot be confirmed or denied.

*(SEAL)*

Dated this _____ day of _____, 20_____.

Signed _____
*(Signature of Secretary or Chair)*

**Please attach a statement pertaining to disciplinary action, if any.*

Title _____

14. If applicable, **attach Collaborative Management Agreement** (Note: this document is required to practice dental therapy.)

## DISCLOSURE QUESTIONS

| | YES | NO |
|---|---|---|
| 15. Have you ever been suspended from practice, reprimanded, censured or otherwise disciplined or disqualified as a professional? (*If so, attach a statement indicating reason for action, dates, disposition and address of licensing authority in possession of record.)* | ❑ | ❑ |
| 16. Do you have any criminal charges pending against you? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)* | ❑ | ❑ |
| 17. Have you ever been convicted of a felony, gross misdemeanor or misdemeanor? *(If so, attach a statement giving full details including reason, dates, name and location of court, and case number.)* | ❑ | ❑ |
| 18. Are there any unsatisfied judgments against you that resulted from the practice of a dental profession? *(If so, attach a statement giving details including nature of judgment, dates and reasons for non-payment.)* | ❑ | ❑ |

YES NO

19. Based on your assessment or that of another professional, has your use of alcohol or drugs, or the existence of a physiological or psychological medical condition, in any way ever impaired or limited your ability to practice any profession with reasonable skill and safety?
If yes, please (1) explain the use or medical condition, and (2) explain whether the impairment(s) or limitation(s) caused by your use of alcohol or drugs or by the existence of your physiological or psychological medical condition are reduced or ameliorated because you receive ongoing treatment or because of the manner in which you have chosen to practice. *(Please provide these explanations on a separate attachment to your application.)* ❑ ❑

**20. TESTIMONIALS - FROM TWO DENTAL THERAPY INSTRUCTORS OR DENTISTS WITH WHOM YOU ARE ACQUAINTED (for at least one year) BUT NOT RELATED TO AND NOT INCLUDED ELSEWHERE ON THIS APPLICATION:**

This certifies that I have been personally acquainted with _____ for _____years, that I know him/her to be of good professional character and hereby recommend him/her to the Minnesota Board of Dentistry for licensure to practice dental therapy in Minnesota.

Name_____ Address _____

City _____ State _____ Zip _____ Phone # _____

❑ Dental or ❑ dental hygiene/therapy school graduated from _____on _____/_____/_____

Licensed in (state or province) _____License Number _____

_____
***(Original Signature)*** *(Date)*

This certifies that I have been personally acquainted with _____ for _____years, that I know him/her to be of good professional character and hereby recommend him/her to the Minnesota Board of Dentistry for licensure to practice dental therapy in Minnesota.

Name_____ Address _____

City _____ State _____ Zip _____ Phone # _____

❑ Dental or ❑ dental hygiene/therapy school graduated from _____ on _____/_____/_____

Licensed in (state or province) _____License Number _____

_____
***(Original Signature)*** *(Date)*

22. **REFERENCES -- Acquaintances**
Persons with whom you are personally acquainted but not related to and not included elsewhere on this application (two required).

Name _____ Occupation _____
Address _____
City _____ State _____ Zip _____ Phone _____

Name _____ Occupation _____
Address _____
City _____ State _____ Zip _____ Phone _____

23. **REFERENCES -- Dentists**
Dentists with whom you are personally acquainted but not related to and not included elsewhere on this application (two required).

Name _____ Occupation _____
Address _____
City _____ State _____ Zip _____ Phone _____

Name _____ Occupation _____
Address _____
City _____ State _____ Zip _____ Phone _____

24. **PHOTOGRAPH**

***For identification purposes, please tape one passport size photograph here, taken within the last six months.***

25.

**AFFIDAVIT OF APPLICANT**

STATE OF _____ )
COUNTY OF _____ ) ss.

I, _____, the applicant being first duly sworn, certify that I am the person referred to in this application for licensure to practice dental therapy in Minnesota, that under penalty of perjury all the information contained in this application and in any attachment or additional document submitted herewith is true and correct and that all persons and organizations, whether public or private, are authorized to release to the Minnesota Board of Dentistry any information, files or records requested in connection with this application.

APPLICANT'S ORIGINAL SIGNATURE _____
*(Sign before a Notary Public)*

Sworn to before me this _____ day of _____, 20 ____

My Commission expires _____ *(SEAL)*

_____
*Notary Public Signature*

## NOTES – PLEASE READ CAREFULLY:

a. Please be sure all FOUR pages of this application are completely filled out. Incomplete applications WILL be returned to you without action pursuant to Minnesota Rule 3100.1500.

b. Remember to attach the required original documents or NOTARIZED copies listed in items 8, 9, and 10 *(A notarized copy is* a *photocopy that is certified to be a true copy of the original document and is signed and stamped/sealed by a notary public.)*

**c. Photocopy of current BLS Healthcare Provider CPR certification from the AHA or ARC.**

d. Your check or money order in the amount listed on page 1 of this application should be payable to the **Minnesota Board of Dentistry**. Pursuant to Minnesota Statutes Chapter 604.113, there will be a $20 service charge on all checks not honored by your bank.

## NITROUS OXIDE

**If you intend to provide Nitrous Oxide, you must submit the Nitrous Oxide application form.**
The Nitrous Oxide Application form can be found at:
http://mn.gov/boards/assets/Nitrous%20Appl.%20Revised%2010-2015_tcm21-76069.pdf

_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ OFFICE USE BELOW _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

| | | |
|---|---|---|
| ____ DIP ____ | ____ PHOTO ____ | ____ COLL AGMT ____ |
| ____ DT. EX. ____ | ____ AFFID. ____ | ____ REF./ TESTIM. ____ |
| ____ JURIS ____ | ____ FEE ____ | ____OTHER ____ |

12/9/15